

CLINICAL NEGLIGENCE BRIEFING

Clinical Consent and Article 2 HRA

"Life is pleasant. Death is peaceful. It's the transition that's troublesome."
Isaac Asimov, 1920-1992

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Clinical Consent: A Brief Overview A Piper

"Every human being of adult years and sound mind has a right to determine what should be done with his body, and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages". (Schloendorff v Society of New York Hospital 103 NE 92 (1914) at 93-94, per Cardozo J)

Any treatment of a patient requires consent. This includes research work. Ordinarily the consent must be that of the patient. If the patient is not himself competent to give consent, then it may be given by a third party acting with lawful authority. Exceptionally consent can be dispensed with on grounds of necessity or emergency. Absent such consent, medical treatment becomes an assault.

The patient's consent must be a legally "valid" consent, for which the following 3 ingredients are essential:

- The patient must be legally competent, and thereby capable of consenting to the proposed treatment. In practice this means that he must be an adult (or a child of sufficient intelligence and understanding, which matters will be assumed for children who have reached the age of 16 pursuant to section 8 of the Family Law Reform Act 1969) and of sound mind;
- The consent must be freely given by the patient exercising his own free will (this is the concept of voluntary consent, untainted by undue influence (as to which, see the case of a young Jehovah's witness injured in a car crash who had refused a blood transfusion with her mother present: *Re T (refusal of treatment)* [1993] Fam 95), fraud, misrepresentation or other vitiating factors);
- The person consenting must be adequately informed, both as to the nature and potential consequences of the proposed treatment, and its alternatives (which might, of course, include non-treatment).

According to Lord Woolf in *Pearce v United Bristol NHS Healthcare Trust*, it is the responsibility of the treating doctor to inform patients of any "significant risk" which would reasonably affect the patient's judgment in giving consent.

The current trend seems to be for the courts to expect doctors to give increasing detail of the potential risks to patients in advance of operations. So in *Chester v Afshar* [2004] UKHL 41, it was held that even though surgery was non-negligently performed, the treating neurosurgeon was nonetheless liable to his patient because he had omitted to warn her of the small but unavoidable risk that the operation, even if properly performed, might in fact worsen her back condition.

Because the neurosurgeon had not warned the patient of that small risk, she was unable to make a properly informed choice as to whether to undergo the treatment recommended, or when to have the operation.

Although the absence of a warning did not increase the risk which was inherent in having the operation, it did prevent the patient from choosing for herself whether or not to go ahead with the operation with full knowledge of the potential consequences.

The crucial factor with regard to information as to the risks of a given operative procedure is the size of the risk in issue. In *Pearce v United Bristol Healthcare NHS Trust* (1999) 48 BMLR 118 (in which case leave to appeal to the House of Lords was refused), the CA held that a risk of stillbirth of the magnitude of just 0.1% to 0.2% was rightly not regarded as significant by the relevant clinician. Reference was made to the *dicta* in *Sidaway*, which suggests that a risk of 10% or more is "significant", but that decision is now almost 25 years old, and medical practices have moved on in the interim (in this regard see *Gold v Haringey HA* [1988] QB 481, which might arguably be decided differently today on the failure to warn issue).

Holman J usefully summarised the law which governs conflicts between doctors and the families of their patients in *The NHS Trust v A* [2007] EWHC (Fam) (July 18th 2007), which dealt with the situation where the court is invited to make a decision as to appropriate treatment where the wishes of parents conflict with the medical advice of the treating clinician.

In determining the best interests of the child the court must have regard to the medical, emotional, sensory (pleasure, pain and suffering), and instinctive (human instinct to sur-

vive) considerations, doing the best that it can to balance the conflicting views. Whilst considerable weight must be attached to the prolongation of life, it may not be a decisive factor and may be outweighed if the pleasure and quality of life will be small, whilst the ongoing pain and suffering will be great.

Within the last year we have had the decision of Cranston J in *Birch v University College London Hospital NHS Trust* [2008] EWHC 2237 (QB), in which it was held that there could be circumstances where a duty to inform a patient of the significant risks of a medical procedure would not be discharged unless the patient was made aware that fewer or no risks were associated with another procedure.

Janet Birch claimed damages for injuries consequent upon vascular surgery. She was given a catheter angiogram, which was a *Bolam* reasonable approach to her situation; but whilst she was told of the increased risks of a catheter angiogram, she was not told of the alternative (non-invasive) option of an MRI scan.

It was held (on the facts) that in order to discharge the duty to inform the patient of significant risks associated with a given surgical procedure, the doctor must also inform the patient that no (or fewer) risks were available with an alternative procedure.

Ms Birch was informed of the risks involved with catheter angiography, but not the comparative risks of MRI, and there were special circumstances to justify the imposition of a duty to inform her of the comparative risks. Had she been so informed, she would have elected to undergo the non-invasive MRI procedure and would not have suffered the stroke that occurred in the course of the (unnecessary) angiographic surgery. She was entitled to damages accordingly.



Clinical Practice and the Right to Life E Bishop

The case of *Savage v South Essex Partnership NHS Foundation Trust* [2008] UKHL 74; [2009] 2 WLR 115 answered some questions about the applicability (some might say intrusion) of article 2 of the European Convention on Human Rights (“Everyone’s right to life shall be protected by law...”) to clinical practice, but left others open. It is expected that some of these unanswered questions are soon to be resolved, at first instance at least, by Simon J in the case of *Rabone v Pennine Care NHS Trust*, (trial in May 2009 – judgment awaited).

In *Savage*, the House of Lords decided that in circumstances where a patient suffering from mental illness has been detained under the Mental Health Act 1983, those treating him or her may commit a violation of article 2 if they

know or ought to know that the patient presents a real and immediate risk of suicide and they fail to do all that can “reasonably be expected” to prevent the death (applying the test in *Osman v United Kingdom* [2000] 29 EHRR 245 and *Keenan v United Kingdom* [2001] 33 EHRR 913).

One difficulty is trying to discern whether their lordships decided that the duty to take protective steps applied to patients who are not detained but nevertheless present a real and immediate risk of suicide. Baroness Hale appeared to confine her decision to detained patients, but Lord Rodger seemed to suggest that the duty is wider, and may apply to voluntary patients (Lord Rodger at para 72).

A further problem arises as a result of Lord Scott’s obiter remarks about the legal standing of those who bring proceedings under the 1998 Act. He did not think that Mrs Savage’s daughter qualified as a “victim”, as defined by s.7 of the 1998 Act. She was not a dependant, she did not represent her mother’s estate and she could not claim that there had been any violation of the state’s investigative obligation.

Rabone was a case involving a voluntary patient. A young woman suffering from mental illness was assessed by a consultant psychiatrist, who advised that she should be allowed home for the weekend. The next day she committed suicide by hanging herself in a local park.

Her parents brought proceedings both at common law (claiming damages for their daughter’s estate under the Law Reform (Miscellaneous Provisions) Act 1934) and also under the Human Rights Act 1998.

The first question that Simon J will have to address is whether the *Osman* test applies to clinical decisions made when a patient has not been detained. If it does not, does a clinician have to be guilty of “gross negligence” or professional misconduct for a violation of article 2 to arise?

The judge must also grapple with the parents’ victim status. Whilst it may be thought that they had a right to bring representative proceedings on behalf of their daughter’s estate, by the time of the trial they had settled the LR (MP)A claim. There are a number of Strasbourg cases that suggest that settlement of a claim extinguishes a party’s victim status (see *Powell v United Kingdom* [2000] 30 EHRR CD 362, *Rowley v United Kingdom* Application No.31914/03, *Hay v United Kingdom* Application No. 41894/98). This seems to be the case even where a defendant makes no admission of liability and does not acknowledge a human rights violation.

Simon J’s decision will be awaited with interest by the NHS

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